Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SOUTH TEXAS RADIOLOGY GROUP
PO BOX 29407
SAN ANTONIO, TX 78229

Respondent Name

SOUTHWESTERN BELL TELEPHONE LP

Carrier's Austin Representative Box

Box Number 17

MFDR Tracking Number

M4-11-3702-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "11/19/2010 We billed AT&T as this is what was provided at the time of service…01/21/2011 We contacted the employer & we were provided with Sedgwick Workers Comp information. We faxed claim to Sedgwick…02/01/2011 Received Explanation of Benefits denying date of service 08/29/2010 for Past Filing Deadline…02/15/2011 We received an EOB denying date of service 08/29/2010 as a duplicate bill.

Amount in Dispute: $13.96

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response

Response Submitted by: N/A

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 29, 2010	CPT Code 73030	$13.96	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
3. 28 Texas Administrative Code §102.4 sets out the rules for Non-Commission Communications.
4. Texas Labor Code §408.027 sets out the rules for timely submission of a claim by a health care provider.

5. Texas Labor Code §408.0272 sets out the rules for certain exceptions for untimely submission of a claim by a health care provider.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated January 26, 2011
   - 29- The time limit for filing has expired.
   - 937- Service(s) are denied based on HB7 provider timely filing requirement. A provider must submit a medical bill to the insurance carrier on or before the 95th day after the date of service.

   Explanation of benefits dated February 9, 2011
   - 18-Duplicate claim/service
   - 247-A payment or denial has already been recommended for this service.

   Explanation of benefits dated March 31, 2011
   - 5094- DWC requires request for reconsideration or corrected claims to be submitted within 11 months of the date of service.
   - W4- No additional reimbursement allowed after review of appeal/reconsideration.

Issues

1. Did the requestor submit the medical bill for the services in dispute timely and in accordance with 28 Texas Administrative Code §133.20?
2. Did the requestor submit documentation to support the disputed bills were submitted timely in accordance with Texas Labor Code, Section §408.027 and 28 Texas Administrative Code §102.4?
3. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §133.20(b) states in pertinent part "Except as provided in Texas Labor Code §408.0272…a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided." The requestor states that they initially billed the employer, AT&T because insurance information was not provided at the time of services however this is not one of the exceptions listed in Texas Labor Code §408.0272. No documentation was found to support that Texas Labor Code §408.0272 applies to the service in dispute, for that reason, the requestor in this dispute was required to send the medical bill no later than 95 days after the service in dispute was provided. 28 Texas Administrative Code §102.4(h) states "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery, or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday."
2. Review of the documentation submitted by the Requestor finds a copy of three medical bills with printed date 06/22/11, 01/20/11 and 03/23/11. A fax transmittal page dated 01/21/11 and a copy of patient notes which show that the requestor did not contact the employer until 01/12/11 to obtain the correct workers' compensation information. No documentation was found to sufficiently support that the requestor submitted a bill to the respondent within 95 days from the date the services were provided.
3. In accordance with Texas Labor Code §408.027, the Requestor has forfeited the right to reimbursement due to untimely submission of the medical bill for the service in dispute.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		01/13/2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.